EC-2
Rev. Sept 2011

Hawaii Employer-Union Health Benefits Trust Fund

EC-2: Enrollment Form for Retirees

Clear Form

PLEASE SUBMIT THIS FORM EC-2 TO THE EUTF

SECTION 1: RETIREE DATA

Please complete all applicable fields below. Social Security numbers are required to process new retirees and dependent enrollments. **

Name (Last, First, Middle)

_____

Home Phone (_____) _____

Mobile Phone (_____) _____

Other Phone (_____) _____

Email _____

Residence Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

☐ Open Enrollment

Retiree's Social Security Number (SSN) or EUTF ID Number

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/_____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)
(☐ Check this box if status change)

_____/_____/_____

If you are including your Spouse or Domestic Partner in your health benefit plans, please complete Section 4

☐ Mid-Year Qualifying Event (describe)

_____

Event Date: _____/_____/_____

Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
DP Date: (MM/DD/YYYY)
(☐ Check this box if status change)

_____/_____/_____

Special Note: If your Spouse or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her

SSN: _____ or

EUTF ID: _____

SECTION 2: COVERAGE AND DEDUCTION START SELECTION

Skip this section if RETIREE does NOT pay towards health plan benefits.

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates. If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section
Adoption, Birth, Marriage, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student

Available Options for this Section

☐ Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs (if no selection is made, this option will be used)
☐ Coverage and premium contributions start 1st day of the **first** pay period√ following event
☐ Coverage and premium contributions start 1st day of the **second** pay period√ following event

√ (1st or 16th of the month)

SECTION 3: PLAN SELECTION

Make your selection by checking the all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection. If you do not make a selection, you will be considered as "waiving" coverage.

Medical Plan Type	**Carrier Selection**	**Choose only one box in each plan selection** Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 **HMSA** Medical No Prescription Drug Coverage	☐	☐	☐	☐
	Prescription Drug (Not a valid selection w/ HMO)	☐	☐	☐	☐
HMO	HMO-**Kaiser** Medical (Includes Prescription Drug Coverage)	☐	☐	☐	☐
Other Plans		**Cancel/Waive**	**Self**	**2-Party**	**Family**
Dental	Hawaii Dental Service	☐	☐	☐	☐
Vision	Vision Service Plan	☐	☐	☐	☐
Life	Royal State National	☐	☐		

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents enrolled or who you want to add/delete from your plan.

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step Child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **:Social Security Number is not a required field when submitting an initial EC-2 for new birth. Please be sure to submit an EC-2 to update our records for your newborn once the information received/issued by SSA.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐

Detailed eligibility information is available at http://eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.

Dependent Certification and Student Certification– See Section regarding Dependent and Student Certification on "Instructions for Completing Form EC-2" for more information.

I certify that my dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ **(initials)**

I certify that all of my dependent children ages 19 through 23, are full time students at an accredited scholastic institution. _____ **(initials)**

Domestic Partner Certification – See Section regarding Domestic Partner Certification on "Instructions for Completing Form EC-2" for specific instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _____ **(initials)**

SECTION 5: MEDICARE

HRS Chapter 87A-23(4) requires eligible beneficiaries to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF retiree benefit plans. If you or your dependent(s) recently enrolled in Medicare Part B, or have not already done so, please submit a copy of the Medicare card and EUTF Direct Deposit Agreement Form to the EUTF without delay and complete this section to initiate quarterly reimbursement.

Name of Enrollee:

Medicare Claim #: (ID Number listed on the red, white and blue Medicare card)

Non-EUTF Medicare Part D

If you or your dependent(s) are enrolled in a non-EUTF Medicare Part D prescription drug plan, please read Section 5 on the instruction form and enter the name(s) of those enrolled in a non-EUTF Medicare Part D plan.

Name(s):

SECTION 6: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage Self	2-Party	Family
			/ /	☐	☐	☐
			/ /	☐	☐	☐

SECTION 7: RETIREE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the "waive" box, it will be considered a "waive." I understand that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

Retiree Signature: _____ Date Signed: _____

Please submit your signed EC-2 form by mail to:

EUTF
P.O. Box 2121
Honolulu, HI 96805-2121

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite 1520, Honolulu, HI 96813

Customer Service Call Center

Oahu (808) 586-7390
Toll Free 1(800) 295-0089